COUNTY MEDICAL SERVICES PROGRAM
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A County-State
COUNTY MEDICAL SERVICES PROGRAM
CMSP
Partnership in Health Care

CMSP Letter No. : 02-2
Issue Date : August 13, 2002

TO: ALL COUNTY MEDICAL SERVICES PROGRAM (CMSP)
WELFARE DIRECTORS

SUBJECT: REVISED CMSP FORM 219 RIGHTS, RESPONSIBILITIES, AND OTHER INFORMATION

The purpose of this letter is to transmit recent changes to the CMSP eligibility process. On April 25, 2002, the CMSP Governing Board voted to revise the CMSP Form 219.

The former CMSP 219 and CMSP 210 (Attachment to the Statement of Facts) forms have been combined into one new CMSP 219 form. The purpose of this action is to simplify the application process and to reduce the workload of county eligibility staff by not having the client complete an additional form.

Two copies of a camera-ready English version are enclosed and can be used by the county to reproduce an adequate supply. Due to delays in translation, the Spanish version will be sent to you at a later date. CMSP forms are also available on the web at: www.dhs.ca.gov/cmsp (choose "CMSP forms" in the left column).

The English version of the CMSP 210 form is now obsolete. For your Spanish-speaking clients, please continue to use the CMSP 210 SP and the CMSP 219 SP until the new CMSP 219 SP is produced.

This information supersedes any prior instructions given relating to the use of the CMSP 219 and 210 forms. The CMSP Eligibility Manual replacement pages relating to this issue will also be forwarded to you at a later date.

CMSP 219.

CMSP 13.

3-017. CMSP Application for County General Assistance/General Relief (GA/GR) Recipients

The county may follow an abbreviated CMSP eligibility process for recipients of county GA/GR payments who request medical assistance. GA/GR eligibility shall serve as verification of CMSP eligibility until GA/GR eligibility is terminated. Such applicants must sign and complete the following forms:

CMSP 13.

CMSP 219.

CMSP 1153

3-018. Date of Application

The date of application for CMSP shall be the date the completed application is received by the county department.

3-019. Withdrawal of Application--Request for Discontinuance

An applicant or beneficiary may withdraw or request discontinuance at any time. The county shall note such a request in the case file. If a written request is not submitted by the applicant or beneficiary, the county shall issue a Notice of Action (NOA) which indicates that the action is being taken to withdraw the application or discontinue benefits and that the applicant/beneficiary must contact the county to indicate if they desire that the application process or eligibility continue.

3-020. Face-To-Face Interview

A face-to-face interview with the applicant, or the person completing the Statement of Facts, shall be required at the time of application, reapplication, or restoration. Additionally, it may be required at the time of re-determination. The interview:

(A) Shall be completed within 30 days of the date of the application or reapplication.

(B) Shall not be required for persons who have a government representative, such as a public guardian, acting on their behalf.

If you have any questions regarding this notification, please direct them to Ms. Genny Fleming, in the CMSP Unit, at (916) 327-3867.

William L. Alameda, Chief
County Medical Services Program

Enclosure

cc: Ms. Maria Tirado
Medical Services Specialist
ISAWS CAST
5330 Primrose Drive, Suite 137
Fair Oaks, CA 95628

Ms. Genny Fleming
County Medical Services Program
Department of Health Services
1800 Third Street, Room 100
P.O. Box 942732
Sacramento, CA 94234-7320

COUNTY MEDICAL SERVICES PROGRAM (CMSP)
RIGHTS, RESPONSIBILITIES AND OTHER INFORMATION

Print name of applicant	Date
Print name of person acting for applicant	Relationship to applicant

Be sure you have read every item, and sign and date. Read the following carefully before signing.

- I understand that I am applying for the County Medical Services Program and that I am *not* applying for the state Medi-Cal Program.
- I understand the *Statement of Citizenship, Alienage, and Immigration Status* (MC 13) has been completed for Medi-Cal, and will also serve for determination of all persons potentially eligible for CMSP.

CMSP Rights, Responsibilities, and Other Information

You have the right to:

- Ask for an interpreter to help you in applying for CMSP benefits if you have difficulty in speaking or understanding the English language.
- Be treated fairly and equally regardless of your race, color, religion, national origin, sex, age, or political beliefs.
- Apply for CMSP benefits and to be told in writing whether or not you qualify for CMSP, even if the county representative tells you during the interview that it appears that you are, or are not now, eligible.
- Review manuals containing the rules of the CMSP if you want to question the basis on which your eligibility is approved or denied.

  Receive a Benefits Identification Card (BIC) as soon as possible if you have a medical emergency.
- Have all information you give to the county department kept in the strictest confidence.
- Be told about the rules for retroactive CMSP eligibility.

  Qualify for the CMSP by reducing your property reserve to within the CMSP property limit by the last day of any month, including the month of application.
- Receive an explanation of possible ways that you may spend your excess property as long as you receive adequate consideration.

  Speak to a social service worker about other public or private services or resources that may be available to you.
- Lower any share-of-cost you may have by providing past unpaid medical bills that you still owe.
- Request a hearing from the county if you are dissatisfied with an action taken, or not taken, by the county Department of Social Services. If you wish such a hearing, you must request one within 90 days of the date the Notice of Action was mailed to you. If you do not receive a Notice of Action, you must request the hearing within 90 days of the date that you became aware of the action of which you are dissatisfied.

You have the responsibility to:

- Complete a status report when provided with one by the county and to return it to the county by the due date.
- Present when requested verification that you are a resident of the county in which you are applying for CMSP.
- Tell your medical provider (doctor, dentist, etc.) that you have applied for CMSP or are a CMSP beneficiary.
- Sign and keep your BIC and use it only to obtain necessary health care.
- Take your BIC to your medical provider when you receive medical care, as soon as possible if you receive services and do not have your BIC with you.

- Provide a social security number to the county or apply for one.
- Apply for Medicare benefits if you are blind, disabled, or aged 64 years and 9 months or older and are eligible for these benefits.
- Apply for any income which may be available to you or your family members.

  Report to the county department any health care insurance which you have or are entitled to have.
- Use any health insurance which you have before using the CMSP.
- Report to the county department when CMSP benefits received are a result of an accident or injury caused by some other person's action or failure to act.
- Cooperate with the county if your case is selected for a quality control review.
- Cooperate with Medi-Cal regulations if you are potentially eligible for Medi-Cal. If you do not cooperate and you are found ineligible for Medi-Cal, you will not be eligible for CMSP benefits.

YOU HAVE THE RESPONSIBILITY TO NOTIFY YOUR COUNTY ELIGIBILITY WORKER WITHIN TEN DAYS WHENEVER:

- Your income or your family's income (including wages, social security payments, pensions, veterans payments, loans, etc.) increases, decreases, starts, or stops.
- You move or plan to move to another address in your county, to another county, or to another state or country.
- You plan to be away from your home (residence) for more than 30 days.

  Any person moves into or out of your home.
- You or your spouse enters or leaves a nursing home or long-term care facility.

  You transfer, give away, sell, or obtain any real or personal property (real property means land, house, etc. and personal property means cars, etc.).
- You or your family receives free or earned housing, utilities, food, or clothing.

  You or a family member becomes pregnant or the pregnancy ends.
- You or a family member has a change in child care, transportation, employment, or education expenses.

  You or a family member applies for any disability benefits, such as SSI/SSP, social security, Railroad Retirement, Veterans Benefits, Workers' Compensation, etc.
- You or a family member starts or drops out of school.
- You or a family member has a change in health insurance, citizenship, or immigration status.

I UNDERSTAND THAT:

- When I apply for CMSP benefits I will be evaluated for eligibility for other programs including Medi-Cal.
- If I obtain medical services from a medical provider who is not a CMSP provider, I will be responsible for the cost of the services I receive.

  Based on my income, I may have to pay, or be billed for, some of my own medical expenses each month before the CMSP will begin to pay.
- If I give false or incomplete information, may be found ineligible for the CMSP and may be investigated for suspected fraud.
- The facts I give will be checked by computer with information from employers, the Franchise Tax Board, Social Security Administration, banks, welfare, and other agencies.

If I, or a person I am applying for, do not have documentation of satisfactory immigration status, or the person I am applying for, may be eligible only for emergency CMSP services.

- If I do not report changes promptly, and I receive CMSP benefits that I am not eligible for, I may have to repay the CMSP for those benefits.

If I am eligible for other health insurance at no cost to me and do not apply for it or fail to keep such insurance, my CMSP eligibility may be denied or discontinued.

If my medical provider accepts my CMSP for covered services, they cannot bill me for those services except for any share-of-cost that I may have.

PRIVACY AND CONFIDENTIALITY NOTIFICATION

Sections 14011 and 14012 of the Welfare and Institutions Code authorize county social service/welfare departments to collect certain information from you to determine if you or the person(s) you are applying for are eligible for CMSP benefits. The information you provide is confidential and may only be disclosed to certain individuals or organizations and then only to administer the CMSP. This information will be used by the county department to establish initial and ongoing CMSP eligibility; by the State's fiscal intermediary for claims processing purposes; by the California Department of Health Services for BIC production, health insurance identifications, and overpayment recovery actions; for Medicare Buy-In and social security number verification; by the Immigration and Naturalization Service to determine alien status; and by medical services providers and health maintenance organizations for eligibility verification.

Providing this information is mandatory. Failure to do so will result in your ineligibility for CMSP benefits. You have the right to look at your information and may do so at the county department during regularly scheduled office hours.

I realize that if I deliberately make false statements or withhold information, I (or the person on whose behalf I am acting) may lose my CMSP eligibility and/or I can be prosecuted for fraud.

I hereby state that I have read the information on this form and that I fully understand my RIGHTS AND RESPONSIBILITIES to have my eligibility determined for the CMSP and to maintain that eligibility.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

Signature of applicant		Phone number	Date
		( )	
Signature of person acting for applicant	Relationship to applicant	Phone number	Date
		( )	
Signature of witness (If applicant signed with mark)		Phone number	Date
		(	
Signature of person helping applicant complete form/Interpreter		Phone number	Date
Signature of Eligibility Worker (EW) (if applicable)	EW number (if applicable)	Phone number	Date
		( )	